# From Assessment to Action: Linking and Coordinating Emergency Department and Primary Care

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RICHLANDCARE
Community Partners for Healthcare Access

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# About Richland Care

- Location: Columbia, SC
- Gaps in the health care delivery system:

1. Coordination among primary care, acute care, specialists, and emergency department
2. Duplication of Services
3. Limited access to specialists
4. ED as primary care provider
5. Need for patient ombudsman
6. No care management for high utilizers or persons with chronic illnesses

# About Richland Care

- Goal: To develop a sustainable health care delivery system for low-income, uninsured residents of Richland County.

- Activities:
  - Implement a care management system aimed at reducing health disparities, improving health outcomes for chronic illnesses and reducing hospital visits for ACSC and ED visits for non-emergency conditions

# About Richland Care

- Assist low-income, uninsured residents of Richland County to access episodic and preventive services through primary care/medical home and appropriately use healthcare system.
- Maintain and enhance the Richland Care healthcare delivery system to include primary care, specialty care, hospital care, pharmaceuticals, mental health and substance abuse services.
- Maintain the Richland Care Consortium, subcommittee structure and infrastructure.

# About Richland Care

- Target Population: uninsured persons under 200% FPL
- Health care delivery system includes:
  - primary care/medical home.
  - specialists
  - outpatient diagnostics
  - acute care
  - prescription drugs
  - RN Call Line
  - Care Management
  - Ombudsman

# About Richland Care

- Operational since November 2001
- Census as of December 31, 2003:
  - Active participants – 3,696
  - Total participants ever enrolled – 6,258
- Funding
  - HRSA HCAP Grant
  - Three (3) grants from local foundations
  - Value of subsidized health care

# Measurement of Emergency Department Utilization and Hospitalizations for ACSC

- Daily hospital reports of Richland Care participants' ED visits and hospitalizations
- Daily reports of calls to the RN Call Line
- Claims data submitted to Richland Care
- Community-level evaluation

# Richland Care's Care Management Intervention

- Care Managers attempt to contact every participant who visits ED or who is hospitalized
- Obtain the following information re: the visit
  - date and time of day
  - chief complaint
  - did the participant attempt to contact their medical home
  - reason they went to the ED
  - outcome of the visit
- Monthly Report to the Medical Home

# Richland Care's Care Management Intervention

| Patient Name | Date/Time of Visit | During Office Hours? | Hospital Visited | System Reason for Visit | Chief Medical Complaint |
|---|---|---|---|---|---|
| Patient 1 | 12/14/03 | Yes | PH Baptist | Called medical home – no appointment in needed time frame | Shortness of breath |
| Patient 2 | 12/29/03 | Yes | PH Richland | Told by medical home to go to ED | Fever, respiratory symptoms |
| Patient 3 | 12/5/03 | Yes | PH Baptist | Did not attempt to call medical home | Cold |

# Care Management
# Emergency Department Follow Up

During the period May 2003 – December 2003, 596 Richland Care participants made 676 visits to the emergency department, representing an ED visit/1,000 rate of 186.

Based on program enrollment, there were 0.023 visits per member per month (PMPM).

# Richland Care's Community – Level Evaluation

- Patient Satisfaction Survey, which includes a measure of health status
- ED and Hospitalization Study
  - Pre-Post Design
  - NYU ED Algorithm and ACSC
  - Focus on sustainability
- Key Informant Interviews

# Baseline – Years 2000-2001
# NYU ED Disease Classification

| | Age group 18-64 | Non-Emergency (%) | Primary Treatable (%) | Prevent-able (%) | Non-Prevent-able (%) | Total<br><br>(Visits PMPM) |
|---|---|---|---|---|---|---|
| Richland County | 211,593 | 148,055 (85%) | 14,758 (8.5%) | 4,319 (2.5%) | 6,367 (3.7%) | 173,499<br><br>(0.034) |
| Richland Care Partici-pants | 3,155 | 5,602 (83.7%) | 662 (10%) | 225 (3.4%) | 197 (3%) | 6,686<br><br>(0.088) |

# Baseline ED Utilization
# County vs. Richland Care Participants

- For the two years prior to Richland Care, Richland Care participants had 2.59 times the number of ED visits PMPM.

- The county and Richland Care participants' ED utilization for non-emergent visits was comparable – 85% vs. 83.7% respectively.

# Richland Care Participants' ED Utilization May – December 2003

- During the period May-December, 2003, Richland Care participants had 0.023 visits PMPM.
- The combination of having a medical home and the Care Management program has reduced ED utilization by 74%.

# Baseline - Years 2000 - 2001 Ambulatory Care Sensitive Condition (ACSC) and Other Hospitalizations

| | Age Group 18-64 Years | ACSC (%) | Non- ACSC (%) | Total |
|---|---|---|---|---|
| Richland County | 211,593 | 1,554 (3.8%) | 39,243 (96.2) | 40,797 |
| Richland Care Participants | 3,155 | 46 (6%) | 688 (94%) | 734 |

# ACSC in Year 1 of Operations

Richland Care participants' ACSC hospitalizations as a percentage of total admissions dropped to 4.9%.

This change (to 4.9% from 6%) was an 18% decrease compared to baseline.

# Preliminary Thoughts

- Compared to the baseline, Richland Care participants are utilizing 74% less ED resources.

  Way to go team! or did the non-compliant participants leave the program?
- The 18% decrease in Richland Care participants' ACSC hospitalizations could be the result of better access and use of primary care and/or an increase in the number of non-ACSC admissions.

# Preliminary Thoughts (continued)

- More systems issues with primary care than originally anticipated
  - telephone access often not available
  - lack same day appointment slots
  - hours of operation
  - we're doing all we can, let them go to the ED

Therefore, a big question is – Can primary care providers remove these operational barriers?

# Preliminary Thoughts (continued)

- With improved access to the health care system, when should we expect to have worked through the “woodwork” effect, improved use of medical home, and reduced the demand for non-emergent ED visits?

- Drop out rate = 27%

  Is there a dose response effect? How long will it take to instill the culture of “maintaining coverage” vs. “access the ED when I’m sick.”

# Preliminary Thoughts (continued)

- The community-level evaluation has clarified somewhat several issues related to ED use for primary care:

  1. The distribution of Richland Care participants' pre-operational visits among the 4 NYU visit categories was basically the same as the county's visit distribution.

  2. We are enrolling to right target group (2.59 times ED visits PMPM).

- RN Call Line - Does it help or hurt?  Are the RN protocols too conservative?

# Preliminary Thoughts (continued)

- What It's Not

  - Lack of access to primary care – 97% of Richland Care's participants have indicated that they have a usual source of care

  - transportation

  - financial barrier – while there is a charge for most services, these charges are minimal, and the providers have very relaxed collection policies

# Preliminary Thoughts (continued)

- Some primary care providers terminate participants who miss an excessive number of appointments. Guess where the participants seek care while between medical homes!
- Lastly, it takes time to:

  - establish a functioning health care delivery system for this target population

  - collect and analyze information re: the system's functioning

  - make system modifications

Thank You